highlights the possible need for standardized postdischarge outpatient follow-up to decrease the risk of early readmission. Fourth, there was a small reduction of 30-day readmission rate after PE in the recent years.

We recognize several limitations which are inherent to an administrative database. The NRD lacks clinical data to assess risk severity and poses a risk of miscoding and under-coding. In particular, we are not able to differentiate between patients with low and intermediate-risk of PE and cannot quantify PE burden. Additionally, we cannot account for out-of-hospital mortality through NRD which may lead to possible under-estimation for post-PE readmission rates.

In conclusion, in patients who were hospitalized for PE with a history of HF, 30-day all-cause hospitalization rate increased after the index PE hospitalization versus before. This finding is more pronounced in patients with HFrEF as compared to HFpEF.

Declaration of interests

The authors declare that they have no known competing financial interests or personal relations that could have appeared to influence the work reported in this study.

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Meta-Analysis of Aspirin Monotherapy Versus Dual Antiplatelet Therapy After Transcatheter Aortic Valve Implantation

Transcatheter Aortic Valve Implantation (TAVI) is increasingly being performed in patients with severe aortic stenosis.[1] The current American guidelines recommend dual antiplatelet therapy (DAPT) for the first 3 to 6 months after TAVI in patients who are not on anticoagulation.[1] These recommendations have been established based on experts' opinions due to the lack of clinical trials investigating the optimal antithrombotic therapy in this population. More recently, multiple studies have questioned the benefit of DAPT in reducing thromboembolic outcomes and revealed high bleeding events in patients who received DAPT after TAVI compared with aspirin monotherapy.[2–5] Therefore, we conducted a meta-analysis of all randomized controlled trials (RCTs) to assess the safety and efficacy of DAPT versus aspirin monotherapy after TAVI.

We performed a comprehensive electronic databases search for RCTs. Two authors extracted and analyzed the data using STATA v15.1 software. The outcomes of interest were all-cause mortality, stroke, and clinically significant bleeding (defined as valve academic research consortium major, life-threatening or disabling bleeding). We calculated hazard ratios (HRs) and 95% confidence intervals (CIs) to account for differences in follow-up duration using a random-effect model. We also calculated the number need to treat for the clinically significant outcomes.

We identified 4 RCTs[2-5] with 1,086 patients, mean duration of follow up (7 ± 4 months) (age 80 ± 1 years; females 44%), randomizing 9,845 patient-months of follow-up. Compared with DAPT, aspirin monotherapy was associated with a significant reduction of clinically significant bleeding (HR 0.49, 95% CI 0.32 to 0.75, p = 0.001, number need to treat = 19) (Figure). There was no difference between aspirin monotherapy and DAPT in terms of all-cause mortality (HR 1.00, 95% CI 0.62 to 1.62, p = 1.00) and stroke (HR 1.05, 95% CI 0.58 to 1.90, p = 0.87) (Figure).

In conclusion, in patients with severe aortic stenosis who underwent TAVI, an antithrombotic strategy using aspirin monotherapy has reduced the risk of clinically significant bleeding by 50% with no difference in all-cause mortality and stroke compared with DAPT.

Disclosure

None.

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2 September 2020
10 September 2020

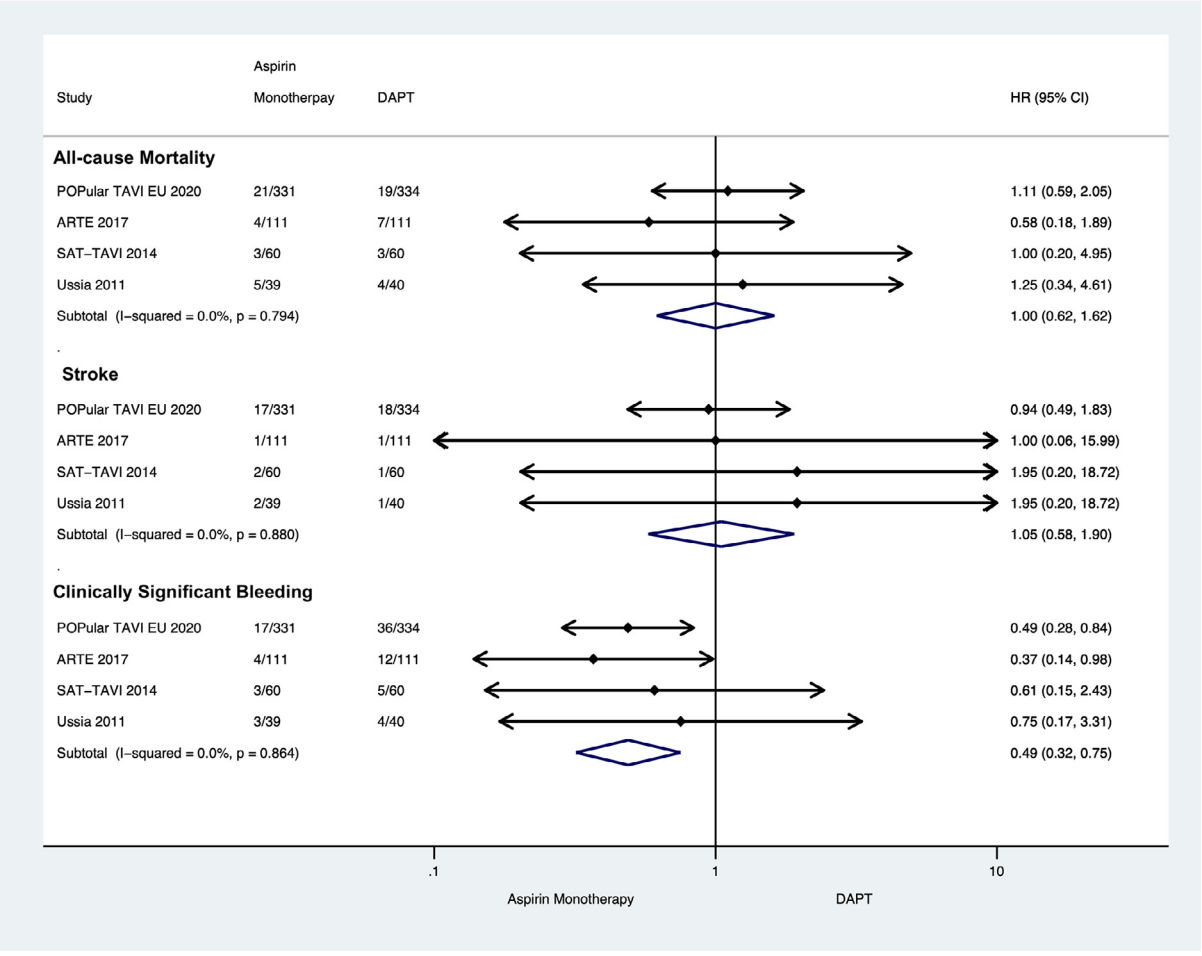

Figure. Forest plot summarizing the main findings from the meta-analysis.

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https://doi.org/10.1016/j.amjcard.2020.09.024